STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	05/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00108232. Complaint IN00108232: Substantiated, Federal/State deficiencies related to the allegations are cited at F157 and F314. Survey dates: May 7, 8, 9, 10, 11, and 15, 2012 Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670 Survey Team: Marcia Mital, RN-TC Kelly Sizemore, RN (May 9, 10, 11, and 15, 2012) Sheila Sizemore, RN Regina Sanders, RN Shannon Pietraszewski, RN (May 7, 8, 9, 10, and 11, 2012) Census bed type: SNF/NF: 146 Total: 146 Census Payor Type: Medicare: 15	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey revisit on or after June 7, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Medicaid: 116 Other: 15 Total: 146 Sample: 24 Supplemental sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 18, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify a resident's physician of a pressure area that had reopened on the resident's great right toe for 1 of 24 residents reviewed for	F0157	**F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** A facility must immediately inform the resident; consult with the resident's physician; and if	06/07/2012

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	physicians' notification in a sample of 24. (Resident B) Findings include: Resident B's record was reviewed on 5/7/12 at 1:15 p.m. Resident B's diagnoses included, but were not limited to, diabetes mellitus, anemia, and multiple sclerosis. A nurses' note, dated 4/17/12 at 2:59 p.m., indicated the open area to the resident's right great toe had resolved. The nurses' note indicated the resident's physician had been notified and a new order had been received to discontinue the treatment to the Resident's toe. A nurses' note, dated 4/21/12 at 4:16 p.m., indicated the right great toe was open and pink. There was a lack of documentation in the resident's record to indicate the resident's physician was notified of the resident's great right toe re-opening. An interview on 5/8/12 at 10:05 a.m., the Wound Nurse indicated the nurse had not notified Resident B's physician when the area to the great right toe had reopened on 4/21/12.		known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	

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	This Federal tag relates to complaint IN00108232. 3.1-5(a)(3)		· Resident B's physician was notified on April 27, 2012 during a wound clinic visit. Her primary physician and her physician at the wound clinic are the same. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · A skin sweep was completed and residents physicians were notified of any abnormal findings. · All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Nursing staff will be educated on Physician/Family Notification by the SDC/designee by 5/29/12. · Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. The Physician Telephone Orders and the 24 Hour Report sheets are audited by the Unit Managers and/or designee · to ensure resident change of condition is reported to the physician, physician orders are	

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			followed through timely and care plans are updated daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Unit Managers will complete a “Change of Condition” CQI tool daily x 4 weeks, weekly x 8 weeks and monthly ongoing thereafter to monitor family and physician notification compliance. · The audits are reviewed by the CQI committee and action plans are developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action.	

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F0223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal abuse related to a CNA yelling at a resident, during a random observation of 1 resident of 24 residents for abuse in a total sample of 24. (Resident C) Findings include: Resident C's record was reviewed on 05/08/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to: schizophrenia, seizure disorder, malnutrition, respiratory failure, circulatory shock, shortness of breath, diabetes mellitus, and congestive heart failure. A Quarterly Minimum Data Set (MDS) Assessment, dated 4/28/2012, indicated the resident's cognition was intact. On 5/8/12 at 2:45 p.m., upon entering the resident's room, CNA #1 was overheard	F0223	**F223 FREE FROM ABUSE/INVOLUNTARY SECLUSION** The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · C.N.A. #1 was suspended pending the outcome of the investigation. Resident #C was interviewed by the Unit Manager immediately following the report by the ISDH surveyor regarding the incident. · The allegation was investigated and found to be unsubstantiated and the resident denies any feelings of abuse or neglect.	06/07/2012

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	stating to the resident in a loud tone of voice "put you on fluid restriction" and "Don't talk to me like I am crazy." During an interview with Resident C, at 2:50 p.m., the resident was tearful. The Resident indicated CNA #1 was upset because she had a "boo boo" (verified with resident that boo boo meant bowel movement). She indicated CNA #1 took her coffee and dumped it out when she wasn't done and told her that she was going to put her on a fluid restriction. Resident C indicated CNA #1 was not happy with her job and shouldn't take it out on her. She also indicated that this was not the first time CNA #1 had yelled at her and did not want her to take care of her anymore. The Administrator was notified of CNA #1 yelling at the resident on 5/8/12 at 2:45 p.m. 3.1-27(a)(1) 3.1-27(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents that live in the facility have the potential to be affected by the alleged deficient practice. · All staff will be educated by the Director of Nursing Services/designee on the Abuse Policy and Reporting by 5/29/12. **What measures will be put into place or what systemic changes you will make to** ensure that the deficient practice does not recur · All staff will be inserviced monthly on the Abuse Policy at the all staff meeting by the SDC/designee ongoing. · During Customer Care rounds (Monday – Friday), as well as nursing rounds per shift daily all residents will be interviewed regarding any concerns regarding resident's rights and abuse. Findings will be documented on the Daily Rounds Checklist and the Customer Care Rounds Sheets and be addressed immediately. · The Daily Rounds Checklists and Customer Care Rounds Sheets will be reviewed during daily meetings by the ED/designee for compliance.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · The DNS/designee will complete an “Abuse Prohibition and Investigation” CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up. Action plans will be developed as needed for issues identified to improve compliance.	

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to follow the facility's policy to ensure a resident was free from verbal abuse related to a CNA yelling at a resident for 1 resident of 24 residents reviewed for abuse in a total sample of 24. (Resident C) Findings include: Resident C's record was reviewed on 05/08/12 at 10:00 a.m. The resident's diagnoses included, but are not limited to schizophrenia, seizure disorder, malnutrition, respiratory failure, circulatory shock, shortness of breath, diabetes mellitus, and congestive heart failure. A Quarterly Minimum Data Set (MDS) Assessment, dated 4/28/2012, indicated the resident's cognition was intact. On 5/8/12 at 2:45 p.m., upon entering the resident's room, CNA #1 was overheard stating to the resident in a loud tone of voice "put you on fluid restriction" and	F0226	**F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · C.N.A. #1 was suspended pending the outcome of the investigation. Resident #C was interviewed by the Unit Manager immediately following the report by the ISDH surveyor regarding the incident. · The allegation was investigated and found to be unsubstantiated and the resident denies any feelings of abuse or neglect. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **· All residents have the potential to be affected by the**	06/07/2012

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	"Don't talk to me like I am crazy." During an interview with Resident C, at 2:50 p.m., the resident was tearful. The Resident indicated CNA #1 was upset because she had a "boo boo" (verified with resident that boo boo meant bowel movement). She indicated CNA #1 took her coffee and dumped it out when she wasn't done and told her that she was going to put her on a fluid restriction. Resident C indicated CNA #1 was not happy with her job and shouldn't take it out on her. She also indicated that this was not the first time CNA #1 had yelled at her and she did not want her to take care of her anymore. The Administrator was notified of CNA #1 yelling at the resident on 5/8/12 at 2:45 p.m. During an observation on 5/8/12 at 2:45 p.m., the West Unit Manager was observed taking CNA #1 to her office and then walked the CNA out of the building. According to the facility policy titled, "Abuse Prohibition, Reporting, and Investigation," dated February 2010, received from the Administrator as current indicated "It is the policy of American Senior Communities to protect residents from abuse including physical		**alleged deficient practice.** · All staff will be educated by the Director of Nursing Services/designee on the Abuse Policy and Reporting by 5/29/12. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · All staff will be inserviced monthly on the Abuse Policy at the all staff meeting by the SDC/designee ongoing. · During Customer Care rounds (Monday – Friday), as well as nursing rounds per shift daily all residents will be interviewed regarding any concerns regarding resident's rights and abuse. Findings will be documented on the Daily Rounds Checklist and addressed immediately. · The Daily Rounds Checklists will be reviewed during daily meetings by the ED/designee for compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The DNS/designee will complete an "Abuse Prohibition and Investigation" · CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to	

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	abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds....Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tones...Mental Abuse-includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation...." 3.1-28(a)		the CQI Committee for review and follow up. · Action plans will be developed as needed for issues identified to improve compliance.	

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F0280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, and interview, the facility failed to ensure residents' care plans were developed and updated, related to, activities, medications, pressure ulcers, urinary incontinence, and vision for 4 of 24 residents reviewed for care plans in a total sample of 24. (Residents #30, #59, #78, and #130) Findings include: 1. Resident #30's record was reviewed on 5/9/12 at 9:52 a.m. Resident #30's diagnoses included, but were not limited to, senile dementia, depression, and hypertension.	F0280	**F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the	06/07/2012

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	A CAA (Care Area Assessment Summary), dated 3/28/12, indicated the resident would be care planned for the problem areas of activities and urinary incontinence. Review of Resident #30's care plans, dated 4/18/12, indicated a lack of documentation of care plans for the problem areas of activities and urinary incontinence. An interview on 5/9/12 at 11:00 a.m., the East Unit Manager indicated there were no care plans in the resident's record for activities and urinary incontinence. 2. Resident #59's record was reviewed on 5/10/12 at 8:20 a.m. Resident #59's diagnoses included, but were not limited to, depression and hypertension. A CAA summary, dated 4/16/12, indicated the facility would proceed to care plan for the problem area of vision. Review of the resident's care plans, dated 4/18/12, lacked documentation of a care plan for the problem area of the resident's vision. An interview on 5/11/12 at 8:50 a.m., the East Unit Manager, indicated Social		participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · **The care plans for Residents #30, #59, #78 and #130 have been reviewed and updated as indicated.** How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · All resident care plans have been reviewed for accuracy. · The Interdisciplinary Team will be re-educated by the DNS/designee on individualized care plan completion by 5/29/12. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Residents care plans will be developed upon admission,	

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	155166	A. BUILDING 00 B. WING	05/15/2012

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	Services had assessed the resident for vision and the resident had trouble reading small print. The East Unit Manager indicated the resident had not been care planned for the problem area of vision. 3. Resident #78's record was reviewed on 05/9/12 at 10:35 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A Significant Change MDS Assessment,		annually and with significant change and reviewed at least quarterly by the IDT and updated as needed. · The care plan will be completed as indicated based on the issues identified with the completion of the comprehensive MDS/CAA process. · The care plan meeting guideline form will be utilized by the MDS Coordinator /designee to ensure triggered CAAS requiring a care plan will have a care plan in place. · The DNS is responsible to ensure resident's plan of care is an accurate reflection of residents needs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · DNS/designee will complete a "Care Plan" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review. An action plan may be developed for identified issues.	

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	dated 01/24/12, indicated the resident was frequently incontinent of urine and was a risk for pressure area. A Significant Change MDS Assessment Care Area Assessment (CAA), dated 01/24/12, indicated the facility was going to proceed with a care plan for incontinency and risk for pressure areas. There was a lack of documentation to indicate a care plan had been initiated for urinary incontinence and pressure ulcer risk. During an interview on 05/09/12 at 11:50 a.m., MDS Nurse #3 indicated there was no care plan initiated for urinary incontinence and pressure ulcer risk. 4. Resident #130's record was reviewed on 05/08/12 at 1:15 p.m. The resident's diagnoses included, but were not limited to, chronic respiratory failure and convulsions. A Physician's Recapitulation Order, dated 05/12, indicated an order for Lovenox (blood thinner) 40 mg (milligrams). The care plans, dated 4/13/12, lacked documentation a care plan for Lovenox had been initiated for the resident.			

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	During an interview on 05/09/12 at 11:50 a.m., MDS Nurse #3 indicated there was not a care plan for the Lovenox. 3.1-3(o)			

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure residents received medications as ordered by the physician for 2 of 24 residents reviewed for following physician's orders in a total sample of 24 . (Residents #62 and C) Findings include:	F0282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #C is receiving medications as ordered. · Resident #62 is receiving medications as ordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents with physician orders have the potential to be affected by the alleged deficient practice. · Licensed nurses will be re-educated on following physician orders by the DNS/designee by 5/29/12. · DNS/designee have audited all resident physician orders to ensure that all	06/07/2012

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			physicians' orders are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Interdisciplinary Team reviews the physician orders at the clinical meeting (Mon-Fri). DNS/designee will assign a license nurse to review the medication · administration records daily to ensure medications have been administered per physician orders. · The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed (Mon-Fri). The "MAR/TAR" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The SDC/designee will complete a "Medication Administration" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up.	

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	1. Resident C's record was reviewed on 5/09/12 at 9:00 a.m. Resident C's diagnoses included, but were not limited to, diabetes mellitus, hypertension, seizure disorder, malnutrition, respiratory failure, circulatory shock, shortness of breath, and congestive heart failure. Resident C's physician's orders, dated 3/27/12 at 2:00 p.m., indicated "D/C (discontinue) omeprazole (stomach medicine) 20 mg (milligram) QD (every day) per peg-tube. Start omeprazole 30 mg QD per peg tube." The MAR (Medication Administration Record), dated 3/12, indicated the omeprazole 30 mg order was to begin on 3/28/12. The MAR lacked documentation to indicate the omeprazole 30 mg had been given between 3/28/12 to 3/31/12. The Nurses' Notes indicated: 3/27/12 at 2:34 p.m., "New order to D/C Omeprazole 20 mg QD per peg-tube. Start Omeprazole 30 mg QD per peg tube. New orders noted Family notified." 3/28/12 at 11:37 p.m., "...Res (resident) cont (continues) omeprazole increase per order."		· Noncompliance with facility procedures may result in disciplinary action.	

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	The MAR, dated 4/12, indicated the resident received the 20 milligrams of omeprazole on 4/1/12 through 4/16/12. During an interview with the DoN (Director of Nursing) and the West Unit Manager on 5/09/12 at 11:55 a.m., the DoN and West Unit Manager indicated the dosage was not correct on the MAR and the resident continued to receive omeprazole 20 mg daily. 2. Resident #62's record was reviewed on 5/8/12 at 1:25 p.m., Resident #62's diagnoses included, but were not limited to, below knee amputation, hypercholesterolemia (high cholesterol), and hypertension. Resident #62's admission physician's orders, dated 4/21/12, from the hospital, indicated "aspirin 325 MG (milligrams) EC (Enteric Coated) tablet. Take 325 Mg by mouth daily." The physician's order was marked as resume. The physician's hospital discharge orders, dated 4/21/12, indicated "aspirin EC tablet 325 mg, 325 mg, oral daily, first dose on FRI (Friday) 3/30/12 at 0900 (9:00 a.m.). DO not crush. Continue No (indicated by a check mark)." The resident's admission physician's orders, dated 4/21/12, indicated orders for			

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	both the enteric coated aspirin 325 milligrams and aspirin 325 milligrams to be administered daily. A physician's order, dated 4/23/12, indicated "...d/c (discontinue) aspirin 325 mg...." The April MAR, dated April 21, 2012, indicated enteric coated aspirin 325 milligrams every day. (Next to the medication was handwritten see other page.) The MAR, dated 4/21/12, indicated the resident received the regular (not enteric coated) aspirin from 4/22/12 thru 4/30/12. The resident continued to receive the non-enteric coated aspirin six days after the aspirin had been discontinued. The May 2012, physician's recapitulation orders lacked documentation of an order for the enteric coated aspirin. The May 2012, MAR lacked documentation of the enteric coated aspirin being given. A physician's order, dated 5/8/12, indicated "Enteric coated aspirin 325 mg po (orally) QD (every day).			

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	An interview on 5/9/12 at 10:00 a.m., The East Unit Manager indicated only one of the aspirin orders should have been discontinued. She indicated the resident should not have received regular aspirin. She indicated the aspirin should have been enteric coated. She indicated there had been two nurses working on the resident's admission orders. She indicated the nurses had discontinued the wrong aspirin and the pharmacy had dropped the aspirin on the physician's orders recapitulation. She indicated the resident should have gotten the enteric coated aspirin for the month of May. 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure appropriate care and services were provided to residents with insulin coverage for high blood sugars (sliding scale) for 3 of 6 residents reviewed for insulin coverage in a total sample of 24. (Residents #51, #57, and #138) Findings include: 1. Resident #138's record was reviewed on 05/07/12 at 1:20 p.m. The resident's diagnoses included, but were not limited to, impaired renal failure and diabetes mellitus. The resident's Physician's Recapitulation Orders, dated 05/12, indicated an order, originally written 03/17/12 for Accu Check (blood sugar monitoring) four times daily, Lantus insulin 20 units at bedtime, and Novolog insulin sliding scale order (insulin administered per blood sugar result) "100-150-seven units,	F0309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **What corrective action(s) will to have been affected by the deficient practice** · Resident's #51, #57 and #138 are receiving insulin as prescribed. · The residents' physicians were notified of the medication error. No new orders were received for any residents noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. · Nurses will be educated on following physician's orders	06/07/2012

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	151-200-eight units, 201-250-nine units...do not use scale at HS (bedtime)." The, "Blood Glucose Monitoring Tool", dated 04/12, indicated the following Accu Check results and insulin administration: 04/06/12 at 9 p.m., blood sugar was 243 and nine units of insulin given (should not have received sliding scale insulin). 04/07/12 at 9 p.m., blood sugar was 159 and eight units of insulin given. 04/10/12 at 9 p.m., blood sugar was 218 and nine units of insulin given. 04/11/12 at 9 p.m., blood sugar was 202 and nine units of insulin given. 04/17/12 at 6 a.m., blood sugar was 124 and no insulin was given. 04/19/12 at 6 a.m., blood sugar was 134 and no insulin was given. 04/19/12 at 9 p.m., blood sugar was 219 and nine units of insulin given. 04/20/12 at 6 a.m., blood sugar was 127 and no insulin was given. 04/22/12 at 6 a.m., blood sugar was 106 and no insulin was given.		regarding insulin by the SDC/designee by 5/29/12. · DNS/designee have audited all resident physician orders to ensure that all physicians' orders are being followed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Unit Manager/designee will audit the Blood Glucose Monitoring tool daily in clinical meeting (Mon-Fri) to ensure physicians' orders for insulin administration have been followed. DNS/designee will assign a license nurse to review the medication be accomplished for those residents found · administration records daily to ensure medications have been administered per physician orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · The Unit Managers will complete the "MAR/TAR" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up.	

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	04/23/12 at 9 p.m., blood sugar was 229 and nine units of insulin was given. 04/24/12 at 9 p.m., blood sugar was 244 and nine units of insulin was given. 04/27/12 at 6 a.m., blood sugar was 125 and no insulin was given. 04/28/12 at 9 p.m., blood sugar was 194 and eight units of insulin was given. 04/29/12 at 9 p.m., blood sugar was 232 and nine units of insulin was given. 04/30/12 at 11 a.m., blood sugar was 113 and no insulin was given. The, "Blood Glucose Monitoring Tool," dated 05/12, indicated the following Accu Check results and insulin administration: 05/02/12 at 9 p.m., blood sugar was 273 and 10 units of insulin was given. 05/04/12 at 9 p.m., blood sugar was 183 and eight units of insulin was given. During an interview on 05/07/12 at 1:50 p.m., the West Unit Manager indicated the resident did not receive her insulin as ordered.		· Noncompliance with facility procedures may result in disciplinary action.	

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	2. Resident #51's record was reviewed on 05/10/12 at 10:25 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and kidney failure. The Physician's Recapitulation Orders, dated 05/12, indicated, "...Novolog...per sliding scale 3 times daily...151-200=2 units, 201-250=4 units..." The, "Capillary Blood Glucose Monitoring Tool," dated 04/12, indicated the resident's 4 p.m. blood sugar on 04/02/12 was 212 and no insulin had been administered. The, "Capillary Blood Glucose Monitoring Tool," dated 05/12, indicated the resident's 4 p.m. blood sugar on 05/08/12 was 169 and no insulin was administered to the resident. During an interview on 05/10/12 at 11:05 a.m., the Director of Nursing indicated the resident had not received the insulin as ordered by the physician. 3. Resident #57's record was reviewed on 5/10/12 at 10:50 a.m. Resident #57's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, and asthma. Physician recapitulation orders, dated			

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	May 2012, indicated an order (originally ordered 3/23/12) for blood sugar checks three times daily with Humalog (insulin) sliding scale. Physician recapitulation orders, dated May 2012, indicated an order (originally ordered 3/23/12) for Humalog 100 units/milliliter, inject subcutaneous per sliding scale three times daily with meals: 100-150= 4 units 151-200= 6 units 201-250= 8 units 251-300= 10 units 301-350= 12 units 351-400= 14 units Call MD if less than 70 or greater than 400 Capillary Blood Glucose Monitoring Tools, indicated blood glucose levels and how much insulin was given, on the following dates and times: 4/12/12 at 4 p.m. 115 and no insulin was given 4/13/12 at 6 a.m. 118 and no insulin was given 4/17/12 at 6 a.m. 117 and no insulin was given 5/7/12 at 4 p.m. 153 and 4 units of insulin given 5/8/12 at 6 a.m. 159 and 4 units of insulin			

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	given During an interview with the East Unit Manager, on 5/10/12 at 1 p.m., she indicated the insulin was not given as ordered on 4/12, 4/13, 4/17, 5/7, and 5/8. 3.1-37(a)			

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VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to notify the resident's physician when a area re-opened and failed to thoroughly assess a resident with a pressure ulcer (B), and failed to administer a protein supplement as ordered to promote healing (C). This affected 2 of 8 residents with pressure ulcers in a sample of 24 residents. (Residents B and C) Findings Include: 1. Resident B's record was reviewed on 5/7/12 at 1:15 p.m. Resident B's diagnoses included, but were not limited to, diabetes mellitus, anemia, and multiple sclerosis. An annual MDS (minimum data set) assessment, dated 3/27/12, indicated Resident B was alert and oriented. The MDS assessment indicated the resident	F0314	**F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident B's physician was notified on April 27, 2012 during a wound clinic visit. Her primary physician and her physician at the	06/07/2012

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	was dependent with two staff assist for bed mobility and transfers. The MDS assessment indicated the resident was nonambulatory, had impairment for movement on both sides of the body, and was always incontinent of bowel. The resident had 3 stage II pressure ulcers present upon admission. A care plan, dated 1/3/12, indicated the resident had an open area to the great right toe. A Pressure wound skin evaluation report, dated 3/14/12, indicated the right great toe was a stage II pressure ulcer. The notes indicated "...met to discuss skin status-Resident conts (continues) with wounds...R (right) gt (great) toe...Severe contractures cont to BLE (bilateral lower extremities). Root cause of wounds conts (continues) to be pressure secondary to contractures..." A physician's order, dated 3/20/12, indicated "Cleanse r (right) gr (great) toe c/ (with) 0.9% ns (normal saline) apply medihoney (type of wound treatment) fluffed gauze abd (abdomen) pad et (and) gauze roll." A nurses' note, dated 4/17/12 at 2:59 p.m., indicated the open area to the resident's right great toe had resolved. The nurses'		wound clinic are the same. The re-opened area was assed. · Resident C's physician was notified and no new orders were received. The Promod was discontinued upon her admission to the hospital on 4/16/12 and not reordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Licensed nurses will be re-educated on following physician orders and receive/note/discontinuing physicians' orders by the DNS/designee by 5/29/12. · All residents were assessed to ensure any open areas were being addressed and physicians were notified of any concerns. · DNS/designee have audited all resident physician orders to ensure that all physicians' orders are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur**	

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	note indicated the resident's physician had been notified and a new order had been received to discontinue the treatment to the resident's toe. Further review of nurses' note indicated the treatment to the resident's right great toe was administered on 4/18/12 , 4/19/12, and 4/21/12. A nurses' note, dated 4/21/12 at 4:16 p.m., indicated the right great toe was open and pink. There was a lack of documentation in the resident's record to indicate the resident's physician was notified of the resident's great right toe reopening. An interview on 5/8/12 at 10:05 a.m., the Wound Nurse indicated she could not find an order to discontinue the treatment when the physician was notified of the open area being healed. She indicated the nurse had not notified Resident B's physician when the area to the great right toe had reopened on 4/21/12. A pressure wound skin evaluation, dated 4/10/12, indicated the area to the great right toe was a stage 2 and measured 0.4 centimeter by 0.4 centimeter with a depth less than 0.1 centimeter.		· The Director of Nursing Services is responsible to monitor for facility compliance. · The Interdisciplinary Team reviews the physician orders at the clinical meeting (Mon-Fri). · Skin assessments are conducted twice weekly during shower/bed bath by a charge nurse to identify any skin concerns. · DNS/designee will assign a license nurse to review the medication administration records daily to ensure medications have been administered per physician orders. · The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed (Mon-Fri). The MAR/TAR CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Unit Managers will complete the "MAR/TAR" and the "Skin Management Program" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in	

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	There was no further documentation of a pressure wound skin evaluation report until 5/8/12. The pressure wound skin evaluation report, completed by the Wound Nurse, dated 5/8/12, indicated the area to the great right toe was a stage 2 and measured 0.4 centimeter by 0.4 centimeter and was at a depth of 0.2 centimeter. The depth of the pressure ulcer had increased.. On 5/9/12 at 2:30 p.m., the Wound Nurse was observed to measure the resident's right great toe. The measurements the Wound Nurse recorded were 0.4 centimeter by 1 centimeter with a depth of less than 0.1 centimeter. 2. Resident C's record was reviewed on 5/09/12 at 9:00 a.m. Resident C's diagnoses included, but were not limited to, diabetes mellitus, hypertension, seizure disorder, malnutrition, respiratory failure, circulatory shock, shortness of breath, and congestive heart failure. A physician's order, dated 3/28/12 at 12:30 p.m., indicated an order for "Promod (protein supplement) 60 cc (cubic centimeters) per peg tube (feeding tube) q (every) 8 hours x (for) 30 days." The order indicated promod was ordered to aid with wound healing due to low		disciplinary action.	

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	albumin level. The MAR (Medication Administration Record), dated 4/12, lacked documentation for the order for Promod 60 cc per Peg Tube every 8 hours for the remaining 28 days. The Nurses' Notes indicated: 4/01/12 at 2:37 a.m., "Cont (continue) Promod per order." 4/01/12 at 1:34 p.m., "Promod received for wound healing." 4/01/12 at 7:53 p.m., "Receives promod for wound healing." A nurses' note, dated 5/8/12 at 6:32 a.m., indicated "Areas to right buttocks resolved." During an interview, with the West Unit Manager on 5/09/12 at 11:40 a.m., the West Unit Manager indicated the Promod did not get transcribed or written on the 4/12 physician's recapitulation or the MAR. This Federal tag relates to complaint IN00108232. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on record review and interview, the facility failed to ensure a resident was accurately assessed for bladder incontinence and provided treatment to restore as much normal bladder functioning as possible for 1 of 17 incontinent residents in a sample of 24. (Resident #30) Findings include: Resident #30's record was reviewed on 5/9/12 at 9:52 a.m. Resident #30's diagnoses included, but were not limited to, senile dementia, depression, and hypertension. An admission MDS (Minimum Data Set) assessment, dated 3/26/12, indicated Resident #30 was alert and oriented, required extensive assist of two staff for bed mobility and transfers. The MDS assessment indicated the resident was	F0315	**F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER** Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · A bladder assessment was completed for resident #30 and the resident need sheet and care	06/07/2012

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	nonambulatory and was dependent with two staff assist for toilet use. A CAA (Care Area Assessment Summary), dated 3/28/12, indicated the resident would be care planned for the problem area of urinary incontinence. Review of Resident #30's care plans, dated 4/18/12, indicated a lack of documentation of a care plan for the problem area of urinary incontinence. An interview on 5/9/12 at 11:00 a.m., the East Unit Manager indicated there was not a care plan in the resident's record for urinary incontinence. An admission bladder assessment, dated 3/23/12, indicated the resident was "always continent." An ADL (Activities of Daily Living) record, dated March 2012, indicated the resident was incontinent on the following dates: 3/19/12, six times 3/20/12, eight times 3/21/12, six times 3/22/12, six times 3/23/12, five times 3/24/12, nine times 3/25/12, six times		plan has been updated. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who reside at the facility have the potential to be affected by the alleged deficient practice. · Licensed nurses will be re-educated on Bladder Assessments by the DNS/designee by 5/29/12. · MDS Coordinator/designee audited all current resident Bladder Assessments for accuracy and all residents with discrepancies identified received a new bladder assessment. The care plan was updated as well as the resident needs sheet to reflect the changes. Bladder assessments are completed by the DNS/designee upon admission, re-admission, significant change, quarterly, annually and when an indwelling urinary catheter is removed. The MDS Coordinator/designee will audit all of the bladder assessments to ensure completion and accuracy. A new bladder assessment will be completed · when discrepancies are noted. The resident needs sheet will be updated based on the new assessment. · The DNS/designee will	

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	Further review of the ADL sheets for March, April, and May, 2012, indicated the resident was incontinent. The resident care/need sheet, dated 5/7/2012, indicated the resident was continent. There was a lack of documentation in the resident's record to indicate the resident was on a toileting program or how often she was being taken to the toilet. During an interview on 5/9/12 at 11:00 a.m., the East Unit Manager indicated the resident was frequently incontinent from 3/19/12 thru 3/23/12. She indicated the bladder assessment was incorrect. She indicated the resident was not on a toileting program and the care/needs sheet was incorrect. 3.1-41(a)(2)		monitor for compliance. · Noncompliance with facility procedures may result in disciplinary action. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Data to develop a plan of care for Incontinence/Continence will be obtained from the ADL documentation. When the bladder assessment is completed MDS will complete the Care Plan and the resident needs sheet will be updated. · The care plan will be completed as indicated based on the issues identified with the completion of the comprehensive MDS/CAA process. · The care plan meeting guideline form will be utilized by the MDS Coordinator /designee to ensure triggered CAAS requiring a care plan will have a care plan in place. Bladder assessments are completed by the DNS/designee upon admission, re-admission, significant change, quarterly, annually and when an indwelling urinary catheter is removed. The MDS Coordinator/designee will audit all of · the bladder assessments to ensure completion and accuracy. A new bladder assessment will be completed when discrepancies	

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			are noted. The resident needs sheet will be updated based on the new assessment. · The DNS is responsible to ensure resident's plan of care and resident need sheet is an accurate reflection of residents needs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Restorative Nurse will complete the "Bladder Program" and "Assessment" CQI tool will be utilized weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review and interview, the facility failed to monitor residents' oxygen saturation (O2 SAT) [oxygen level in the blood] as ordered for 2 of 7 residents using oxygen in a sample of 24. (Residents #110 and #130) Findings include: 1. Resident #110's record was reviewed on 05/10/12 at 8:15 a.m. The resident's diagnoses included, but were not limited to, respiratory failure and convulsions. The Physician's Recapitulation Orders, dated 05/12 and originally ordered on 01/09/12, indicated to check the pulse oximetry (O2 saturations) twice daily. The "Ventilator/Aerosol Flow Sheets," indicated the resident's O2 saturations had been completed once a day not two times a day as ordered on 04/06/12, 04/16/12,	F0328	**F328 TREATMENT/CARE FOR SPECIAL NEEDS** The facility must ensure that residents receive proper treatment and care for the following special services: Injections, parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Trachesostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #110 and resident #138 have their oxygen stats checked as physicians ordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who use oxygen	06/07/2012

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	04/20/12, 04/26/12, 04/29/12, and 05/06/12. During an interview on 05/10/12 at 8:45 a.m., the Respiratory Therapy Manager indicated the oxygen saturations had not been completed as ordered on the above dates. 2. Resident #130's record was reviewed on 05/08/12 at 1:15 p.m. The resident's diagnoses included, but were not limited to, tracheotomy and chronic respiratory failure. The Physician's Recapitulation Orders, dated 05/02 and originally dated 03/19/12, indicated an order for pulse oximetry twice daily. The "Ventilator/Aerosol Flow Sheets", indicated the resident's O2 saturations had been completed once a day not twice a day as ordered on March 22, 23, and 31, 2012, April 3, 10, 14, 17, 19, 23, and 29, 2012. During an interview on 05/09/12 at 10:15 a.m., the Respiratory Therapy Manager indicated the O2 saturations were not completed as ordered on the above dates. 3.1-47(a)(6)		have the potential to be affected by the alleged deficient practice. · Licensed nurses and respiratory staff will be re-educated on following physician orders by the SDC/designee by 5/29/12. · DNS/designee have audited all resident physician orders in regards to oxygen stats to ensure that all physicians' orders are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** Respiratory Supervisor/designee is responsible to ensure compliance with facility procedure for compliance with physician orders. · Respiratory Supervisor/designee will assign a Respiratory Therapist to review the "Ventilator/Aerosol Flow Sheets" daily to ensure physician orders are followed for accuracy. · The Respiratory Supervisor/designee will audit the "Ventilator/Aerosol Flow Sheets" daily Monday through Friday for accuracy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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			program will be put into place · Respiratory Supervisor/designee will complete the “Oxygen Therapy” CQI tool 3 times weekly x 4, the once weekly x 4 weeks and then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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F0333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free from a significant medication error, related to high blood pressure medication for 1 of 24 residents reviewed for significant medication errors in a total sample of 24. (Resident #138) Findings include Resident #138's record was reviewed on 05/07/12 at 1:20 p.m. The resident's diagnoses included, but were not limited to, impaired renal failure and diabetes mellitus. The hospital discharge orders, dated 03/16/12, indicated an order for Lopressor (antihypertensive) 12.5 mg (milligrams), twice daily. Hold if systolic blood pressure (SBP) less than 105 and hold on dialysis days (Monday, Wednesday, and Friday). The facility admission orders, dated 03/16/12, indicated an order for Lopressor (antihypertensive) 12.5 mg (milligrams), twice daily. Hold on dialysis days (Monday, Wednesday, and Friday).	F0333	F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #138 physician was notified of the medication error. No new orders were received for this resident. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who use antihypertensive medication have the potential to be affected by the alleged deficient practice. · DNS/designee have audited all resident physician orders to ensure that all physicians' orders are being followed for antihypertensive medication. · Licensed nurses will be re-educated on following physician orders by the DNS/designee by 5/29/12.	06/07/2012

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	155166	A. BUILDING 00 B. WING	05/15/2012

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	The MAR (Medication Administration Record), dated 4/12 and 5/12, lacked documentation to hold the Lopressor as ordered above. The 2010 Nursing Spectrum Drug Book, pages 750-751, indicated Lopressor precautions were to use cautiously in renal impairment. The MAR, dated 04/12, indicated the resident received the Lopressor on Mondays on 04/02/12 at 9 a.m. and 9 p.m., 04/09/12 at 9 p.m., 04/16/12 at 9 a.m. and 9 p.m., 04/23/12 at 9 p.m., and 04/30/12 at 9 a.m. and 9 p.m. The MAR, dated 04/12, indicated the resident received the Lopressor on Wednesdays on 04/04/12 at 9 p.m., 04/11/12 at 9 p.m., 04/18/12 at 9 p.m., and 04/25/12 at 9 a.m. and 9 p.m. The MAR, dated 04/12, indicated the resident received the Lopressor on Fridays on 04/06/12 at 9 p.m., 04/13/12 at 9 a.m. and 9 p.m., 04/20/12 at 9 p.m., and 04/27/12 at 9 p.m. The MAR, dated 05/12, indicated the resident received the Lopressor on Wednesday 05/02/12 at 9 p.m. and Friday 05/04/12 at 9 p.m.		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Director of Nursing Services is responsible to monitor for facility compliance. · The Interdisciplinary Team reviews the physician orders at the clinical meeting (Mon-Fri). · DNS/designee will assign a license nurse to review the medication administration records daily to ensure antihypertensive medications have been administered per physician orders. · The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed (Mon-Fri). The MAR/TAR CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Unit Managers will complete the "MAR/TAR" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility	

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	During an interview on 05/07/12 at 1:05, the Staff Development Nurse indicated the resident's Lopressor had not been held on dialysis days as ordered by the physician. 3.1-25(b)(9) 3.1-48(c)(2)		procedures may result in disciplinary action.	

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F0508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to obtain an x-ray as ordered by a resident's physician for 1 of 24 residents reviewed for radiology testing in a total sample of 24. (Resident #138) Findings include: Resident #138's record was reviewed on 05/07/12 at 1:20 p.m. The resident's diagnoses included, but were not limited to, impaired renal failure and diabetes mellitus. A physician order, dated 04/13/12, indicated an order for a KUB (kidney, ureters, and bladder) x-ray. The resident's record lacked documentation the KUB had been completed as ordered by the physician. During an interview on 05/07/12 at 1:50 p.m., the West Unit Manager indicated the KUB had not been completed. LPN #5 indicated the x-ray company came to	F0508	**F508 PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS** The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #138 physician was notified and the order for the KUB had been discontinued prior but the nurse failed to write the order to discontinue. The physician determined that the KUB was not necessary. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in the facility have the potential to be affected by the alleged deficient practice.	06/07/2012

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	the facility and completed the resident's chest x-ray but could not get the KUB completed. She indicated it was shift change so she was unsure what happened after that. She indicated the KUB had not been rescheduled. 3.1-49(g)		· DNS/designee have audited all resident physician orders to ensure that all physicians' orders are being followed. · Licensed nurses will be re-educated on following physician orders and receive/note/discontinuing physicians' orders by the DNS/designee by 5/29/12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Director of Nursing Services is responsible to monitor for facility compliance. · The Interdisciplinary Team reviews the physician orders/labs/diagnostics at the clinical meeting (Mon-Fri). · DNS/designee will assign a license nurse to review the lab/diagnostics log daily to ensure physician orders are followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The SDC/designee will complete "Labs/Diagnostics" CQI tool will be completed weekly x 4 weeks then monthly ongoing. · Data will be submitted to the CQI Committee for review	

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			and follow up. · Noncompliance with facility procedures may result in disciplinary action.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure records were complete and accurate related to clarification of a resident's allergy, medications, and documentation of medications administered for 2 of 24 residents reviewed for complete and accurate clinical records in a total sample of 24. (Residents #72 and #138) Findings include: 1. A. Resident #72's record was reviewed on 5/07/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to,diabetes mellitus, COPD (Chronic Obstructed Pulmonary Disease), atrial fibrillation, neuropathy, and right above the knee amputation.	F0514	**F514 Clinical Records** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	06/07/2012

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	A physician's recapitulation orders, dated 5/12, indicated an order for alprazolam 0.25 milligrams tablet by mouth every 8 hours as needed for anxiety. A physician's order, dated 5/03/12 at 12:00 p.m., indicated to "D/C (discontinue) previous prn (as needed) ativan...start ativan 0.25 mg PO (by mouth) BID (twice daily)." The MAR, dated 05/12, indicated the resident had an order for prn alprazolam 0.25 mg. The MAR indicated the alprazolam 0.25 mg had been discontinued on 05/03/12. During an interview with the DoN (Director of Nursing) on 5/08/12 at 11:30 a.m., the DoN indicated she was not able to locate a prn order for Ativan. She indicated the resident was on prn alprazolam and that had been discontinued. B. Resident #72's resident information sheet (face sheet) indicated the resident's allergies as follows: ASA (aspirin), codeine sulfate, lyrica, oxycontin, adhesive tape, and latex. The Resident's Physician recapitulation orders, dated 3/23/12 to 3/31/12, lacked documentation to indicate the resident		· Physician orders for resident #72 were clarified her allergy order was discontinued per physicians order. · Resident #138 is receiving her insulin as prescribed. Documentation is accurate to reflect that the resident is receiving insulin as prescribed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Licensed nurses will be re-educated on following physician orders and receive/note/discontinuing physicians' orders by the DNS/designee by 5/29/12. · DNS/designee have audited all resident physician orders to ensure that all physicians' orders are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Interdisciplinary Team reviews the physician orders at the clinical meeting (Mon-Fri). · The Unit	

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	had any allergies. The physician's order recapitulations, dated 4/12 and 5/12, indicated the resident was allergic to hydrocodone. A physician order, dated 3/22/12, indicated "hydrocodone/acetamin (acetaminophen) (pain medication) 10-325 mg tab, Take 2 tablets (20-650 mg) by mouth every 4 hours as needed for pain." The Resident's MAR (Medication Administration Record), dated 3/12, indicated Resident #72 received hydrocodone on 3/23, 3/24, 3/26 twice, 3/28, and 3/31/12. The MAR, dated 4/12, indicated the resident received hydrocodone 4/1, 4/4, 4/5, 4/9 twice, 4/10 twice, 4/13, 4/16 three times, 4/17, 4/18 three times, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24 twice, 4/28. 4/29 twice, and 4/30/12 twice. The MAR, dated 5/12, indicated the resident received the hydrocodone on 5/1 twice, 5/2 twice, 5/3 twice, 5/4 three times, 5/5 three times, 5/6, 5/7 three times, and 5/8/12. A physicians order, dated 5/09/12 at 2:15 p.m., indicated "MD aware of allergy to hydrocodone. It is OK to administer		Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed (Mon-Fri). · DNS/designee will assign a license nurse to review the medication administration records daily to ensure medications have been administered per physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Unit Managers will complete the "MAR/TAR" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter. · Data will be submitted to the CQI Committee for review and follow up. Noncompliance with facility procedures may result in re-education and or disciplinary action.	

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	hydrocodone 10-325 mg 2 tabs q (every) 4hrs (hours) prn (as needed) for pain." A physician's order, dated 5/09/12 at 4:00 p.m., indicated "D/C (discontinue) allergy to hydrocodone." The resident's record lacked documentation of the resident having any adverse reactions to the administration of the hydrocodone. During an interview with the West Unit Manager on 5/09/12 at 2:15 p.m., she indicated the physician was aware of the allergy and still wanted the hydrocodone given. She indicated she had looked through the resident's chart and there was not any documentation related to the resident's allergies to the hydrocodone. She indicated she did not know when the physician had been notified of the allergy. The West Unit Manager indicated she had contacted the pharmacy to inquire about the authorization. The pharmacy was unable to provide any documentation. The pharmacy indicated they had spoke with a nurse on 4/6/12 for authorization and received another verbal authorization on 4/24/12. 2. Resident #138's record was reviewed on 5/7/12 at 1:20 p.m. Resident #138's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and			

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	congestive heart failure. Physician recapitulation orders for May 2012, indicated an order (originally ordered 3/17/12) for Lantus (insulin) inject 20 units subcutaneous daily at bedtime. A MAR (Medication Administration Record) for May 2012 lacked documentation the resident received the insulin. A Significant Change MDS (Minimum Data Set) Assessment, dated 3/22/12, indicated a the resident's cognitive status was intact. During an interview with SDC (Staff Development Coordinator) Nurse on 5/7/12 at 1:05 p.m., she indicated the insulin was not signed as given. During an interview with Resident #138, on 5/7/12 at 1:25 p.m., she indicated she gets her insulin at night. 3.1-50(a)(1) 3.1-50(a)(2)			